its effect hastened by enemata, applications of heat, etc. In desperately severe cases, the neohormonal should be combined with physostigmin and atropin in large doses. In chronic constipation, 20 c.c. should be injected intravenously, and during the first two to four days should be energetically supported by other purgatives, as castor oil, senna, etc.; if the desired effect is not obtained, in this time, 20 to 40 c.c. more should be injected and this again aided by purgatives. In especially stubborn cases the dose may be increased to 30 c.c. or more. Some of this dose should be given intravenously because the full dose injected into a muscle would cause distressing pain. In children under ten years of age, about half of the above dosage should be tried. The preparation is well borne even in the first year of life. By the employment of sufficiently large doses, according to Denck, failures with postoperative paresis and chronic constipation will be rare.

Intestinal Stasis.—CASE (*Surg., Gynec., and Obst.*, 1914, xix, 592) says that while ileal stasis has been definitely shown to exist in connection with marked obstructing adhesions or kinkings of the terminal ileum, and while it is likely that spasm of the ileocecal sphincteric mechanism may be another factor in the production of ileal stasis, it seems demonstrated that incompetency of the ileocolic valve offers a further and more tangible explanation of ileal stasis and that it is probably the essential causative factor in the majority of cases of stasis in the terminal ileum. Ileocecal valve incompetency is almost always associated with the clinical evidences of intestinal stasis. Not all these patients have, as yet, a well developed alimentary toxemia. His experience in the Roentgen study in these cases of intestinal stasis, both before and after operation, leads him to distinctly oppose the tendency toward operative interference for their relief. Surgery should not be seriously considered as the cure for ileal stasis until a most thoroughgoing trial has been made of the various dietetic and mechanical measures at our command. If an operative measure seems advisable, recognition of ileocolic valve incompetence as a potent cause of ileal stasis may present a course of surgical treatment free not only from the dangers associated with short-circuiting with or without colectomy, but actually calculated to restore normal physiological function.

A Contribution to the Surgery of the Lesser Sac of the Peritoneum.—ZIEMBICKI (*Zentralbl. f. Chir.*, 1914, xli, 1489) gives the following *resumé* of the conditions which have been found in the lesser peritoneal cavity: (1) Hernia through the foramen of Winslow, of which Jeanbrau and v. Riche reported about 20 cases; (2) liver abscess from cholelithiasis through the foramen of Winslow (very rare); (3) blood collections from hemorrhagic pancreatitis or the rupture of an aneurysm of the splenic artery; (4) lymph collections from contusions and wounds, or post-traumatic cysts; (5) blood effusions or inflammation in consequence of pancreatic necrosis with perforation into the lesser peritoneal cavity; (6) pseudo-cysts and pancreatic cysts which develop in the lesser peritoneal cavity. Ziembicki reports 2 cases. In one, operation showed the fluid collection in this cavity to consist of bile. The patient recovered from simple drainage, and this with the fact that the gall-bladder could not be found at the time of operation led to the conclusion that the collection was due to a much dilated gall-bladder. Tumors developing primarily in the lesser peritoneal cavity are exceedingly rare. Only 6 cases were found in the literature, all of which were sarcomata and found at autopsy. The Lembert anatomico-pathological institute possess a specimen, also a sarcoma. Ziembicki had the opportunity of observing an eighth case, which also came to autopsy and was a sarcoma.

Regeneration of Cartilage and Bone, with a Special Study of These Processes as They Occur at the Chondrocostal Junction.—HAAS (*Surg., Gynec., and Obst.*, 1914, xix, 604) says that the periosteum is directly and actively concerned in the regeneration of bone. In the very early stages the periosteum proliferates to form cartilaginous tissue, which is later transferred into bone. The exact changes from cartilage to bone cannot be determined. There is considerable evidence in favor of direct change from cartilage to bone. There is at times the appearance of the osteoblasts forming bone and substituting the cartilage. Therefore it seems as though both processes can take place at the same time. The regeneration of bone also takes place from the marrow and cortical bone, but in a more limited degree and at a later period than that from the periosteum. The regeneration of cartilage takes place almost entirely from the perichondrium. It proceeds by a direct proliferation of all the layers of the perichondrium beneath the outer fibrous tissue. There is some evidence in favor of the view that the connective-tissue is also transformed into cartilage under the stimulation of the neighboring cartilage or perichondrium. There is a slight amount of regeneration of cartilage from the original cartilage near the perichondrium, but the remainder of the cut end tends to undergo degenerative changes. The extent of the removed cartilage exerts no influence on the regeneration. There is no evidence of calcareous changes in the regenerated cartilage, even as late as forty-six days.

The Phenolsulphonephthalein Test from the View-point of the Abdominal Surgeon.—TRACY (*Surg., Gynec., and Obst.*, 1914, xix, 734) employed the test in about 300 cases, the material for this paper being based upon the observations of the first 100 cases. He says that it does not seem possible to work out the minimum percentage phthalein output which will be safe to undertake surgical operations, nor is it safe from the phthalein test to determine what cases should or should not be subjected to operation. He believes it will never be possible to determine this point from the phthalein test, as the functional activity of a kidney varies under numerous circumstances and at different times. In determining whether or not a patient should be subjected to operation, the history, clinical symptoms, and physical examination are of much greater value than any renal functional test ever devised. The phthalein test used in conjunction with the clinical symptoms, history, and physical examination is of value. A small percentage output should put the surgeon on his guard and cause him to study the patient most carefully before undertaking an operation. The phthalein test should be used only as one of the many methods of investigation in ascertaining the condition of the patient.